MS RECOVERING NURSE PROGRAM IOP & AFTERCARE FORM

(Explanation: the RNP requires that this form be submitted by the treatment counselor for the purpose of evaluating participant's compliance with monitoring requirements. This report must be filled out and faxed in by the treatment counselor at the end of each month)

DATE FORM COMPLETED: _____ NAME OF AGENCY_____

_____ _____
PRINTED NAME OF COUNSELOR SIGNATURE OF COUNSELOR

CLIENT'S NAME: _____
CLIENT HAS ATTENDED _____ OUT OF _____ SESSIONS
CLIENT'S ABSENCE HAD PRIOR APPROVAL: YES ( ) NO ( )

DESCRIBE TREATMENT GOALS:	**WHAT STEPS HAS CLIENT TAKEN TOWARD GOALS TO DATE?**
ISSUES BESIDES SUBSTANCE USE:	**MEDICATIONS FOR PSYCH SYMPTOMS:**

TREATMENT	**POOR**	**FAIR**	**GOOD**	**EXCELLENT**
Group Participation				
Acceptance of disease in self				
Ability to identify own behaviors				
Operating on a feeling level				
Able to accept feedback				
Able to give feed back				
Attitude	_____	_____	_____	_____
Completion of group assignments				

Does client have a relapse prevention plan with identified triggers in place?	**Yes ( ) No ( )**
Has patient integrated into the 12 step community?	**Yes ( ) No ( )**
Does patient have a sponsor?	**Yes ( ) No ( )**
What step is patient currently working?	
COUNSELORS COMMENTS:	
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